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Statutes:

All laws specifically codified by the General Assembly of the State of Georgia through the 2015 Regular Session of the General Assembly.

Annotations of Judicial Decisions:

Case annotations reflecting decisions posted to LexisNexis® through April 3, 2015. These annotations will appear in the following traditional reporter sources: Georgia Reports; Georgia Appeals Reports; Southeastern Reporter; Supreme Court Reporter; Federal Reporter; Federal Supplement; Federal Rules Decisions; Lawyers' Edition; United States Reports; and Bankruptcy Reporter.

Annotations of Attorney General Opinions:

Constructions of the Official Code of Georgia Annotated, prior Codes of Georgia, Georgia Laws, the Constitution of Georgia, and the Constitution of the United States by the Attorney General of the State of Georgia posted to LexisNexis® through April 3, 2015.

Other Annotations:

References to:

Emory Bankruptcy Developments Journal.
Emory International Law Review.
Emory Law Journal.
Georgia Journal of International and Comparative Law.
Georgia Law Review.
Georgia State University Law Review.
John Marshall Law Review.
Mercer Law Review.
Georgia State Bar Journal.
Georgia Journal of Intellectual Property Law.
American Jurisprudence, Second Edition.
American Jurisprudence, Pleading and Practice.
American Jurisprudence, Proof of Facts.
American Jurisprudence, Trials.
Corpus Juris Secundum.
Uniform Laws Annotated.
American Law Reports, First through Sixth Series.
American Law Reports, Federal.

Tables:

In Volume 41, a Table Eleven-A comparing provisions of the 1976 Constitution of Georgia to the 1983 Constitution of Georgia and a Table Eleven-B comparing provisions of the 1983 Constitution of Georgia to the 1976 Constitution of Georgia.

An updated version of Table Fifteen which reflects legislation through the 2015 Regular Session of the General Assembly.

Indices:

A cumulative replacement index to laws codified in the 2015 supplement pamphlets and in the bound volumes of the Code.

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TITLE 33

INSURANCE

VOLUME 24

Chap.

VOLUME 25

Law reviews. — For article, "When Do State Laws Determine ERISA Plan Benefit Rights," see 47 J. Marshall L. Rev. 145 (2014). For article, "Nondiscrimination in Insurance: The Next Chapter," see 49 Ga. L. Rev. 1 (2014). For article, "Public Officers and Employees: Employees' Insurance and Benefit Plans," see 31 Ga. St. U.L. Rev. 177 (2014).

CHAPTER 1

GENERAL PROVISIONS

33-1-9. Insurance fraud; venue; penalty; exemption.

JUDICIAL DECISIONS

Venue for staged accidents.

When the defendant, an attorney, knew that the client had received approximately $15,000 at closing, but told the client's insurer that the client had not been paid for the sale of the property, because the indictment specifically charged the defendant with violating the insurance fraud statute; and the indictment further indicated, tracking the statute's own language, that the fraudulent misrepresentation was the statement of the client that the client had suffered a loss of $117,849.82, the indictment was sufficient to withstand a general demurrer. Sallee v. State, 329 Ga. App. 612, 765 S.E.2d 758 (2014).

Evidence sufficient to convict attorney for role in insurance scheme. — Evidence was sufficient to convict the defendant of insurance fraud as the defendant, an attorney, aided the client in making a false or fraudulent written statement for the purpose of procuring or attempting to procure the payment of a false claim because, even though the defendant knew that the client's loan on the property had been paid off on August 4, 2006, at the closing, the defendant nonetheless filed the client's signed proof of loss statement with the client's insurer on December 8, 2008, in which the client falsely claimed a loss of approximately $118,000 under the insurance policy. Sallee v. State, 329 Ga. App. 612, 765 S.E.2d 758 (2014).

33-1-24. (Effective January 1, 2016) Insurance requirements for transportation network companies and their drivers.

(a) As used in this Code section, the term:

(1) "Personal vehicle" means a registered motor vehicle that is used by a transportation network company driver in connection with providing services for a transportation network company.

(2) "Transportation network company" means a corporation, partnership, sole proprietorship, or other entity that uses a digital network or other means to connect customers to transportation network company drivers for the purposes of providing transportation for compensation including, but not limited to, payment, donation, or other item of value. The term shall not include emergency or nonemergency medical transports.

(3) "Transportation network company customer" or "customer" means an individual who uses a transportation network company to connect with a driver to obtain services in such driver's personal vehicle, from an agreed upon point of departure to an agreed upon destination.

(4) "Transportation network company driver" or "driver" means an individual who uses or permits to be used his or her personal vehicle to provide transportation network company services. Such driver need not be an employee of a transportation network company.

(5) "Transportation network company services" or "services" means:

(A) The period of time a driver is logged on to the transportation network company's digital network and available to accept a ride request until the driver is logged off, except for that time period described in subparagraph (B) of this paragraph; and

(B) The period of time a driver accepts a ride request on the transportation network company's digital network until the driver completes the transaction or the ride is complete, whichever is later.

Transportation network company services shall not include transportation provided using a taxi, a limousine carrier as defined in Code Section 40-1-151, or any other commercially registered motor vehicle and commercially licensed driver.

(b) A transportation network company shall maintain or cause to be maintained a primary motor vehicle insurance policy that:

(1) Recognizes the driver as a transportation network company driver and explicitly covers the driver's provision of transportation

network company services as defined in paragraph (5) of subsection (a) of this Code section;

(2) During the time period defined in subparagraph (a)(5)(A) of this Code section, provides a minimum of $100,000.00 for bodily injuries to or death of all persons in any one accident with a maximum of $50,000.00 for bodily injuries to or death of one person and $50,000.00 for loss of or damage to property of others, excluding cargo, in any one accident; and

(3) During the time period defined in subparagraph (a)(5)(B) of this Code section, provides a minimum of $1 million for death, personal injury, and property damage per occurrence and provides uninsured and underinsured motorist coverage of at least $1 million per incident.

(c) The requirements of subsection (b) of this Code section may be satisfied by either:

(1) A commercial motor vehicle insurance policy purchased by the transportation network company or the driver that provides coverage that meets the requirements set forth in subsection (b) of this Code section; or

(2) An insurance rider to, an endorsement of, or an express provision of coverage for transportation network company services within the driver's personal private passenger motor vehicle insurance policy required by Code Section 40-9-34 which may be combined with an excess policy provided by the transportation network company to meet the requirements set forth in subsection (b) of this Code section.

(d) A transportation network company that purchases an insurance policy to satisfy any of the requirements under subsection (b) of this Code section shall provide the insurance policy to the Commissioner.

(e) An insurance policy required by subsection (b) of this Code section shall be placed with an insurer licensed under this title or with a surplus lines insurer eligible under Chapter 23 of this title.

(f) To the extent the coverage requirements in subsection (b) of this Code section are met by a driver, then such driver shall submit verification of such coverage to the transportation network company. In the event that the insurance maintained by a driver to fulfill the requirements of subsection (b) of this Code section has lapsed or ceases to exist, then the transportation network company shall provide coverage which shall become primary beginning with the first dollar of a claim.

(g)(1) Nothing in this Code section shall be construed to require a personal vehicle insurance policy to provide primary or excess coverage for transportation network company services.

(2) Insurers that write motor vehicle insurance policies in this state may exclude any and all coverage afforded under the owner's insurance policy for any loss or injury that occurs while a driver is logged on to a transportation network company's digital network or while a driver provides transportation network company services. Notwithstanding any other law, a personal vehicle insurer may, at its discretion, offer a personal vehicle insurance policy, or an amendment or endorsement to an existing policy, that covers a driver's vehicle while being used for transportation network company services during the time period specified in this paragraph, with or without a separate charge, or the policy contains an amendment or an endorsement to provide such coverage, for which a separately stated premium may be charged.

(h) The transportation network company shall comply with the following requirements for each driver:

(1) The driver shall be provided a disclosure from the transportation network company containing:

(A) All information and documentation required for compliance with Code Section 40-6-10 if the transportation network company provides any insurance policy required by subsection (b) of this Code section;

(B) Notice that the driver's personal vehicle insurance policy may exclude any and all coverage for injuries to the driver and to others and may exclude the duty to defend or indemnify any person or organization for liability for any loss or injury that occurs while providing transportation network company services; and

(C) Notice that the driver's personal vehicle insurance policy may exclude coverage for damage to the personal vehicle, medical payments coverage, uninsured and underinsured motorist coverage, and other first-party claims;

(2) Such transportation network company shall make the following disclosure to a driver in the driver's terms of service: "If the vehicle with which you provide transportation network company services has a lien against it, you must notify the lienholder that you provide transportation network company services with such vehicle. Providing such transportation network company services may violate the terms of your contract with the lienholder.";

(3) The transportation network company shall include the disclosures required by this subsection in the driver's terms of service in a distinctive clause; and

(4) For purposes of claims coverage investigation and upon request of the transportation network company driver's personal vehicle

insurer, the transportation network company shall provide, within 15 days of such insurer's request, the date and times at which an accident occurred that involved a transportation network company driver and the precise times in the 12 hours preceding and following the accident that the driver logged on and off the transportation network company network or application or otherwise signified availability to provide transportation network company services. Coverage under a motor vehicle insurance policy maintained by the transportation network company shall not be dependent on a personal vehicle insurer first denying a claim nor shall a personal vehicle insurance policy be required to first deny a claim.

(i) In the event the transportation network company is providing primary insurance coverage under subsection (b) of this Code section, the transportation network company's insurer shall assume the costs of defense and indemnification. The transportation network company shall notify the driver and the driver's insurer of any dispute concerning primary coverage within 25 business days of receiving notice of the accident that gives rise to such claim. A personal vehicle insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy shall have a right of contribution against other insurers that provide motor vehicle insurance to the same driver in satisfaction of the coverage requirements of this Code Section at the time of loss.

(j) In the event the transportation network company is providing primary insurance coverage under subsection (b) of this Code section and the driver or the driver's insurer is named as a defendant in a civil action for any loss or injury that occurs while a personal vehicle is available to provide transportation network company services, the transportation network company's insurer shall have the duty to defend and indemnify the driver and the driver's insurer. (Code 1981, § 33-1-24, enacted by Ga. L. 2015, p. 1280, § 1/HB 190.)

Effective date. — This Code section becomes effective January 1, 2016.

CHAPTER 2

DEPARTMENT AND COMMISSIONER OF INSURANCE

Sec.
33-2-34. Insurance compliance self-evaluative privilege.

33-2-33. (For effective date, see note.) List of written requests for assistance by citizens against insurers.

Delayed effective date. — Section 2 of Ga. L. 1989, p. 633, not codified by the General Assembly, provides: "This Act shall become effective only when the funds necessary to carry out its purposes are appropriated by the General Assembly." Such funds were not appropriated during the 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, or 2015 sessions of the General Assembly.

33-2-34. Insurance compliance self-evaluative privilege.

(a) To encourage insurance companies and persons conducting activities regulated under this title, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with state and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communications relating to voluntary internal compliance audits. The General Assembly hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this state's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance issues. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Code section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

(b) As used in this Code section, the term:

(1) "Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, or audit not otherwise expressly required by law of an insurer or an activity regulated under this title, or other state or federal law applicable to an insurer, or of management systems related to the insurer or activity, that is designed to identify and prevent noncompliance and to improve compliance with those statutes, rules, or orders. An insurance compliance audit may be conducted by the insurer, its employees, or independent contractors.

(2) "Insurance compliance self-evaluative audit document" means any document prepared as a result of or in connection with and not prior to an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, computer generated or electronically recorded information,

phone records, maps, charts, graphs, and surveys, provided that this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document may also include any of the following:

(A) An insurance compliance audit report prepared by an auditor, who may be an employee of the insurer or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) Analytic data generated in the course of conducting the insurance compliance audit.

(c)(1) An insurance compliance self-evaluative audit document is privileged information and is not admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, except as provided in subsections (d) and (e) of this Code section. Documents, communications, data, reports, or other information created as a result of a claim involving personal injury or workers' compensation made against an insurance policy are not insurance compliance self-evaluative audit documents and are admissible as evidence in civil proceedings as otherwise provided by applicable rules of evidence or civil procedure, subject to any applicable statutory or common law privilege, including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(2) If any insurer, person, or entity performs or directs the performance of an insurance compliance audit, an officer or employee involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, shall not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Code section. This paragraph shall not apply if the privilege set forth in paragraph (1) of this subsection is determined under subsection (d) or (e) of this Code section not to apply.

(3) An insurer may voluntarily submit, in connection with examinations conducted under this Code section, an insurance compliance

self-evaluative audit document to the Commissioner, or his or her designee, as a confidential document under subsection (g) of Code Section 33-2-14 without waiving the privilege set forth in this Code section to which the insurer would otherwise be entitled. However, the provision permitting the Commissioner to provide access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. Nothing contained in this subsection shall give the Commissioner any authority to compel an insurer to disclose involuntarily or otherwise provide an insurance compliance self-evaluative audit document.

(d)(1) The privilege set forth in subsection (c) of this Code section shall not apply to the extent that it is expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege; or

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege;

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate such noncompliance within a reasonable time; or

(D) The material contains evidence relevant to the commission of a criminal offense under this title and:

(i) The Commissioner has a compelling need for the information;

(ii) The information is not otherwise available; and

(iii) The Commissioner is unable to obtain the substantial equivalent of the information by any means without incurring unreasonable cost and delay.

(e)(1) Within 30 days after the Commissioner makes a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the insurer that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure. The court has jurisdiction over a petition filed by an insurer under this subsection requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the insurer to file a petition waives the privilege.

(2) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its petition for an in camera hearing all of the information set forth in paragraph (5) of this subsection.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure.

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (c) of this Code section is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in paragraph (2) of subsection (d) of this Code section is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in paragraph (3) of subsection (d) of this Code section is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall provide to the Commissioner at the time of filing any objection to the disclosure:

(A) The date of the insurance compliance self-evaluative audit document;

(B) The identity of the entity conducting the audit;

(C) The general nature of the activities covered by the insurance compliance audit; and

(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(f)(1) An insurer asserting the insurance compliance self-evaluative privilege set forth in subsection (c) of this Code section has the burden of demonstrating the applicability of the privilege. Once an insurer has established the applicability of the privilege, a party seeking disclosure under paragraph (2) or (3) of subsection (d) of this Code section has the burden of proving that the privilege is asserted for a fraudulent purpose or that the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time. The Commissioner, in seeking disclosure under paragraph (3) of subsection (d) of this Code section, has the burden of proving the elements set forth in paragraph (3) of subsection (d) of this Code section.

(2) The parties may at any time stipulate in proceedings under subsection (d) or (e) of this Code section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (c) of this Code section.

(g) The privilege set forth in subsection (c) of this Code section shall not extend to:

(1) Documents, communications, data, reports, or other information required to be collected, developed, maintained, reported, or otherwise made available to a regulatory agency pursuant to this title or other federal or state law, rule, or order;

(2) Information obtained by observation or monitoring by any regulatory agency; or

(3) Information obtained from a source independent of the insurance compliance audit.

(h) Nothing in this Code section shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(i) This Code section shall apply to self-evaluative audits completed before June 30, 2018, but shall not apply to any such audits completed

on or after July 1, 2018, unless authorized by the General Assembly prior to that date. (Code 1981, § 33-2-34, enacted by Ga. L. 2015, p. 839, § 1/HB 162.)

Effective date. — This Code section became effective July 1, 2015.

CHAPTER 4

ACTIONS AGAINST INSURANCE COMPANIES

33-4-6. Liability of insurer for damages and attorney's fees; notice to Commissioner of Insurance and consumers' insurance advocate.

(a) In the event of a loss which is covered by a policy of insurance and the refusal of the insurer to pay the same within 60 days after a demand has been made by the holder of the policy and a finding has been made that such refusal was in bad faith, the insurer shall be liable to pay such holder, in addition to the loss, not more than 50 percent of the liability of the insurer for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action against the insurer. The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith. The amount of any reasonable attorney's fees shall be determined by the trial jury and shall be included in any judgment which is rendered in the action; provided, however, the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, the trial court shall have the discretion, if it finds the jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and

the plaintiff's attorney for the services of the attorney in the action against the insurer.

(b) In any action brought pursuant to subsection (a) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner of Insurance a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same. (Ga. L. 1872, p. 43, § 1; Code 1873, § 2850; Code 1882, § 2850; Civil Code 1895, § 2140; Civil Code 1910, § 2549; Code 1933, § 56-706; Code 1933, § 56-1206, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 712, § 1; Ga. L. 2001, p. 784, § 1; Ga. L. 2015, p. 1088, § 21/SB 148.)

The 2015 amendment, effective July 1, 2015, deleted "and the consumers' insurance advocate" following "Commissioner of Insurance" in the middle of subsection (b).

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

ANALYSIS

BAD FAITH REFUSAL TO PAY

PROCEDURE

3. QUESTIONS FOR JURY OR COURT

Bad Faith Refusal to Pay

Insured party excluded from coverage by terms of policy.

District court did not err when the court found that an insurance company was entitled to summary judgment on an insured's claims that the company committed breach of contract and was liable for bad faith penalties under O.C.G.A. § 33-4-6 because the court denied the insured's claim seeking compensation for damages that occurred to the insured's home and personal property when water, mud, and debris entered the home during a rainstorm; damages the insured sustained were caused by "surface water," as that term was defined under Georgia law, and a provision in the insured's homeowner's policy excluded coverage for damage to the insured's home and personal property that was caused by surface water. Williams v. State Farm Fire & Cas. Ins. Co., No. 14-11100, 2014 U.S. App. LEXIS 13681 (11th Cir. July 17, 2014) (Unpublished).

Procedure

3. Questions for Jury or Court

Summary judgment to insurer proper following theft by computer virus. — As an insurance coverage dispute arose from a theft of the insured's account by a key-logger virus, summary judgment was properly granted to the insurer on the insured's breach of contract and bad faith claims because the loss was within the policy's malicious-code exclusion. Metro Brokers, Inc. v. Transp. Ins. Co., No. 14-12969, 2015 U.S. App. LEXIS 3473 (11th Cir. Mar. 5, 2015) (Unpublished).

33-4-7. Affirmative duty to fairly and promptly adjust in incidents covered by motor vehicle liability policies; actions for bad faith; notice to Commissioner of Insurance and consumers' insurance advocate.

(a) In the event of a loss because of injury to or destruction of property covered by a motor vehicle liability insurance policy, the insurer issuing such policy has an affirmative duty to adjust that loss fairly and promptly, to make a reasonable effort to investigate and evaluate the claim, and, where liability is reasonably clear, to make a good faith effort to settle with the claimant potentially entitled to recover against the insured under such policy. Any insurer who breaches this duty may be liable to pay the claimant, in addition to the loss, not more than 50 percent of the liability of the insured for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action.

(b) An insurer breaches the duty of subsection (a) of this Code section when, after investigation of the claim, liability has become reasonably clear and the insurer in bad faith offers less than the amount reasonably owed under all the circumstances of which the insurer is aware.

(c) A claimant shall be entitled to recover under subsection (a) of this Code section if the claimant or the claimant's attorney has delivered to the insurer a demand letter, by statutory overnight delivery or certified mail, return receipt requested, offering to settle for an amount certain; the insurer has refused or declined to do so within 60 days of receipt of such demand, thereby compelling the claimant to institute or continue suit to recover; and the claimant ultimately recovers an amount equal to or in excess of the claimant's demand.

(d) At the expiration of the 60 days set forth in subsection (c) of this Code section, the claimant may serve the insurer issuing such policy by service of the complaint in accordance with law. The insurer shall be an unnamed party, not disclosed to the jury, until there has been a verdict resulting in recovery equal to or in excess of the claimant's demand. If that occurs, the trial shall be recommenced in order for the trier of fact to receive evidence to make a determination as to whether bad faith existed in the handling or adjustment of the attempted settlement of the claim or action in question.

(e) The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith.

(f) The amount of recovery, including reasonable attorney's fees, if any, shall be determined by the trier of fact and included in a separate

judgment against the insurer rendered in the action; provided, however, the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, the trial court shall have the discretion, if it finds the jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his or her attorney for the services of the attorney.

(g) In any action brought pursuant to subsection (b) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner of Insurance a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same. (Code 1981, § 33-4-7, enacted by Ga. L. 2001, p. 784, § 1; Ga. L. 2015, p. 1088, § 22/SB 148.)

The 2015 amendment, effective July 1, 2015, deleted "and the consumers' insurance advocate" following "Commissioner of Insurance" near the end of the first sentence in subsection (g).

33-7-11. Uninsured motorist coverage under motor vehicle liability policies.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

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PROCEDURE

General Consideration

Insurer entitled to set off. — Trial court did not err in granting the summary judgment motion of the plaintiff's parent's insurer finding that it was entitled to a set-off for the $25,000 paid by the insurer for the other driver because the parent's insurer was the sole difference-in-limits underinsured motorist (UM) carrier whose policy potentially provided coverage for the plaintiff's claims; and, after applying the $25,000 set-off to the $25,000 limits under the policy of the parent's insurer, there was no further coverage with that carrier, no issue of fact remained regarding the availability of UM coverage under that policy, and the parent's insurer was entitled to summary judgment as a matter of law. Donovan v. State Farm Mut. Auto. Ins. Co., 329 Ga. App. 609, 765 S.E.2d 755 (2014).

Named driver exclusion not effective when no written rejection of coverage. — Under O.C.G.A. § 33-7-11, a written rejection of uninsured motorist

General Consideration (Cont'd)

coverage was required to properly exclude an insured's husband from the policy's uninsured motorist coverage; because the record contained no such rejection, the policy's exclusion specifically naming the husband as an excluded driver was ineffective. Roberson v. 21st Century Nat'l Ins. Co., 327 Ga. App. 545, 759 S.E.2d 614 (2014).

Procedure

Late answer filed by uninsured motorist carrier. — Trial court erred in denying an insured's motion for a default judgment and granting the uninsured motorist carrier's motion for summary judgment because the court relied upon a typographical error in case law in determining that the carrier's answer was not filed late and thereby finding that the carrier was not in default. Kelly v. Harris, 329 Ga. App. 752, 766 S.E.2d 146 (2014).

Time for filing answer by uninsured motorist carrier. — Lewis v. Waller, 282 Ga. App. 8 (2006) notes that to the extent that the uninsured motorist carrier (UMC) purports to act directly in the carrier's own name, the carrier's answer is timely if filed within 30 days from service of the answer and complaint upon the UMC; however, in the opinion from Lewis, the phrase "answer and complaint" should actually read summons and complaint, and the Georgia Court of Appeals corrects that typographical error. Kelly v. Harris, 329 Ga. App. 752, 766 S.E.2d 146 (2014).

CHAPTER 8

FEES AND TAXES

33-8-8.1. County and municipal corporation taxes on life insurance companies.

(a) As used in this Code section, the term "life insurance company" means a company which is authorized to transact only the class of insurance designated in Code Section 33-3-5 as class (1).

(b) Life insurance companies are subject to county and municipal corporation taxes levied as follows:

(1) There is imposed a county tax for county purposes on each life insurance company doing business within the state, which tax shall be based solely upon gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the unincorporated area of the counties pursuant to the provisions of this Code section. The rate of such tax shall be 1 percent of such premiums,

except that such tax shall not apply to the gross direct premiums of an insurance company which qualifies, pursuant to Code Section 33-8-5, for the reduction to one-half of 1 percent of the state tax imposed by Code Section 33-8-4. The tax imposed by this Code section shall not apply to annuity considerations; and

(2) Municipal corporations whose ordinances have been filed with the Commissioner are authorized to impose a tax on each life insurance company doing business within the state, which tax shall be based solely upon the gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the corporate limits of the municipal corporation pursuant to the provisions of this Code section; provided, however, that the rate of the tax may not exceed 1 percent of the premiums. The tax imposed shall not apply to annuity considerations.

(c)(1) On March 1, 1984, and on that date in each subsequent year, each life insurance company shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(2) Reserved.

(3) On or before August 1, 1988, and on the same date in each subsequent year, the Commissioner shall collect taxes imposed pursuant to subsection (b) of this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes.

(d) Taxes imposed by subsection (b) of this Code section shall be allocated and distributed to counties and municipal corporations as follows:

(1) A portion of the total amount of life insurance premiums taxable by the state, exclusive of premiums collected by companies which qualify for the reduction to one-half of 1 percent of the state tax, shall be allocated to counties based upon the ratio that the total population of all unincorporated areas in the state bears to the total population in the state. The amount of the tax base so allocated to counties shall be taxed at the rate levied for county purposes. The tax shall be distributed to each county governing authority by the Commissioner based upon a fraction, the numerator of which is the population of the unincorporated area of that county and the denom-

inator of which is the population of all unincorporated areas of the state; and

(2) A portion of the total amount of life insurance premiums taxable by the state shall be allocated to all municipal corporations based upon the ratio that the total population of all municipal corporations bears to the total state population. The amount of the tax base so allocated to municipalities shall be distributed to each municipal corporation based upon the fraction, the numerator of which is the population of that municipal corporation and the denominator of which is the population of all municipal corporations in the state. The amount of the tax base so distributed to each municipality shall be taxed at the rate levied by that municipality; and taxes levied by each municipal corporation shall be distributed based upon the tax rate levied by each such municipal corporation.

(e) On or before January 1 of the first year that the tax is levied, each municipal corporation levying the tax shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance. On or before February 1 of each year the Commissioner shall furnish a list of all municipal corporations levying the tax for that year to each life insurance company in the state.

(f) Life insurance companies may deduct from premium taxes otherwise payable to this state under Code Section 33-8-4, in addition to all credits and abatements allowed by law, the taxes imposed pursuant to subsection (b) of this Code section and paid to the Commissioner on behalf of any county and municipal corporation during the preceding calendar year.

(g) On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute the taxes imposed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(h) Amounts collected by the Commissioner under or due under former Code Section 33-8-8.1 shall be collected and disbursed as provided in former Code Section 33-8-8.1.

(i) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the

United States Bureau of the Census made prior to the first day of September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year. (Code 1933, § 56-1310.1, enacted by Ga. L. 1981, p. 380, § 2; Ga. L. 1983, p. 1595, § 2; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1988, p. 13, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 1; Ga. L. 2009, p. 652, § 2/HB 410.)

Editor's notes. — Ga. L. 2009, p. 652, § 6(b)/HB 410, not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2010".

Pursuant to its own terms, subsection (a.1), as added by Ga. L. 2009, p. 652, § 2/HB 410, concerning exemption from local premium taxes, was repealed effective January 1, 2015.

U.S. Code. — Section 223 of the Internal Revenue Code, referred to in subsection (a.1) of this Code section, is codified at 26 U.S.C. § 223.

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U.L. Rev. 217 (2011).

33-8-8.2. County and municipal corporation taxes on other than life insurance companies.

(a) Counties and municipal corporations are authorized to levy tax at a rate not to exceed 2.5 percent upon the gross direct premiums of all foreign, alien, and domestic insurance companies doing business in this state other than life insurance companies. The tax shall be in addition to the taxes levied by Code Section 33-8-4, and it may be levied upon the gross direct premiums received by such companies during the preceding calendar year. The tax shall be levied upon premiums derived from policies insuring persons, property, or risks in Georgia from January 1 to December 31, both inclusive, of each year without regard to business ceded to or assumed from other companies. The tax shall be imposed upon gross premiums received during the preceding calendar year from direct writing without any deductions allowed from premium abatement of any kind or character or for reinsurance or for losses or expenses of any kind; provided, however, deductions shall be allowed for premiums returned or change of rate or canceled policies; provided, further, that deductions shall be permitted for returned premiums or assessments, including all policy dividends, refunds, or other similar returns paid or credited to policyholders.

(b) The taxes provided in this Code section are county and municipal taxes and shall be levied for county and municipal purposes and shall be collected and distributed as follows:

(1) On or before January 1 of the first year that the tax is levied, each county and municipal corporation levying the tax shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and resolutions and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance or resolution;

(2) On or before February 1 of each year, the Commissioner shall furnish to each insurance company a list of all counties and municipal corporations where the tax as authorized by this Code section has been imposed for the then current year together with the applicable tax rate levied by each such county and municipal corporation and the population percentages by which the taxes are to be allocated to each such county and municipal corporation as provided in this Code section;

(3)(A) On March 1, 1984, and on the same date in each subsequent year, each insurance company upon which a tax is imposed by subsection (b) of this Code section shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(B) Reserved.

(C) On or before August 1, 1988, and on the same date in each subsequent year, the Commissioner shall collect taxes imposed pursuant to this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The premiums tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes;

(4) The total amount of premiums taxable by the state on insurance companies as defined in this Code section shall be allocated to each county unincorporated area and each municipal corporation based upon a fraction, the numerator of which is the population of the unincorporated area or municipal corporation and the denominator of which is the total population of the state. Tax rates levied by each county shall be applied to the premiums allocated to its unincorporated area, and tax rates levied by each municipal corporation shall be applied to the premiums allocated to it; and

(5) On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute the taxes im-

posed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(c) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the United States Bureau of the Census made prior to the first day of September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year.

(d) Any county or municipal corporation which, on January 1, 1983, levied a tax on all premiums of insurance companies, other than life insurance companies, at a rate in excess of 2.5 percent may continue to levy the tax at a rate in excess of 2.5 percent, provided that the rate of such tax shall not exceed the rate which was in effect in such county or municipal corporation on January 1, 1983, reduced annually beginning January 1, 1984, by one-third of the difference between such January 1, 1983, rate and 2.5 percent, so that the rate levied on January 1, 1986, shall not exceed 2.5 percent.

(e) It shall be in contravention of public policy for a county or a municipal corporation that levies taxes for county or municipal purposes on foreign, alien, and domestic insurance companies doing business in this state, as provided in subsection (a) of this Code section, to impose additional taxes or any other fees of any kind for services provided by such county or municipal corporation to such insurance companies for accidents involving motor vehicles except for the following:

(1) Where the coverage for such services is expressly provided by an insurance company to the insured and the services are lawfully billed to the insured;

(2) Where emergency medical services are provided to the insured by the county or municipal corporation, whenever the insured's medical insurance covers the services provided and the insured assigns the right to collect to the service provider; or

(3) Where other services are provided to the insured by the county or municipal corporation which are expressly authorized by state or

federal law to be billed directly to an insurance company. (Code 1981, § 33-8-8.2, enacted by Ga. L. 1983, p. 1595, § 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1985, p. 149, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 2; Ga. L. 2008, p. 292, § 2/HB 977; Ga. L. 2008, p. 490, § 1/SB 348; Ga. L. 2009, p. 652, § 3/HB 410.)

Editor's notes. — Ga. L. 2008, p. 292, § 6(b)/HB 977, not codified by the General Assembly, provides: "Section 2 of this Act shall expire on January 1, 2015, unless the General Assembly acts to extend these provisions." The General Assembly took no action to extend these provisions prior to January 1, 2015, and therefore, subsection (a.1) was repealed effective January 1, 2015.

33-8-8.3. Funding of services, or reduction of ad valorem taxes, in unincorporated areas of counties; powers and duties of governing authority.

(a) The proceeds from the county taxes levied for county purposes, as provided by this chapter, shall be separated from other county funds and shall be used by the county governing authorities solely for the purpose of either:

(1) Funding the provision of the following services to inhabitants of the unincorporated areas of such counties directly or by intergovernmental contract as authorized by Article IX, Section III, Paragraph I of the Constitution of the State of Georgia:

(A) Police protection, except such protection provided by the county sheriff;

(B) Fire protection;

(C) Curbside or on-site residential or commercial garbage and solid waste collection;

(D) Curbs, sidewalks, and street lights; and

(E) Such other services as may be provided by the county governing authority for the primary benefit of the inhabitants of the unincorporated area of the county; or

(2) Reducing ad valorem taxes of the inhabitants of the unincorporated areas of those counties in which the governing authority of a county does not provide any of the services enumerated in paragraph (1) of this subsection to inhabitants of the unincorporated areas. In fixing the ad valorem tax millage rate for the year 1984 and any year thereafter, the governing authorities of such counties shall be authorized and directed to reduce such ad valorem tax millage rate on taxable property within the unincorporated areas of such counties to offset any of the proceeds derived from any tax provided for in this chapter which cannot be expended pursuant to paragraph (1) of this subsection.

(b) In the adoption of the budget utilizing any of the funds derived from the tax imposed by Code Sections 33-8-8.1 and 33-8-8.2 the governing authority of a county shall specify in such budget the amount of such funds expended as authorized by paragraph (1) of subsection (a) of this Code section or used to reduce ad valorem taxes as provided in paragraph (2) of subsection (a) of this Code section. Said budget shall also specify the amount of any other funds expended for such purpose or purposes as are authorized to be expended for services referred to in paragraph (1) of subsection (a) of this Code section. Such provisions shall be spread on the minutes of the meeting at which such budget is adopted. (Code 1981, § 33-8-8.3, enacted by Ga. L. 1983, p. 1595, § 4; Ga. L. 1984, p. 22, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1989, p. 1151, § 1; Ga. L. 1997, p. 561, § 1; Ga. L. 2015, p. 5, § 33/HB 90.)

The 2015 amendment, effective March 13, 2015, part of an Act to revise, modernize, and correct the Code, added "and" at the end of subparagraph (a)(1)(D).

CHAPTER 10

ASSETS AND LIABILITIES

Sec.
33-10-13. Standard valuation.

33-10-13. Standard valuation.

(a) This Code section shall be known and may be cited as the "Standard Valuation Law."

(b) For the purposes of this Code section, the following definitions shall apply on or after the operative date of the valuation manual:

(1) The term "accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in paragraph (2) of subsection (d) of this Code section.

(3) The term "company" means an entity, which (a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and has at least one such policy in force or on claim or (b) has written, issued, or

reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this State.

(4) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) The term "life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) The term "NAIC" means the National Association of Insurance Commissioners.

(7) The term "policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Code section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (p) of this Code section as specified in the valuation manual.

(9) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Code section or as subsequently amended.

(c)(1)(A) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in

this state issued on or after January 1, 1966, and prior to the operative date of the valuation manual. In calculating reserves, the Commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Code section.

(B) The provisions set forth in subsections (e) through (n) of this Code section shall apply to all policies and contracts, as appropriate, subject to this Code section issued on or after January 1, 1966, and prior to the operative date of the valuation manual and the provisions set forth in subsections (o) and (p) of this Code section shall not apply to any such policies and contracts.

(C) The minimum standard for the valuation of such policies and contracts issued prior to January 1, 1966, shall be as required under the laws in effect immediately prior to January 1, 1966, or the minimum provided in subsection (e) of this Code section if less.

(2)(A) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Code section.

(B) The provisions set forth in subsections (o) and (p) of this Code section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(d)(1)(A) Prior to the operative date of the valuation manual, every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The Commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(B)(i) Every life insurance company, except as exempted by regulation, shall also annually include in the opinion required by subparagraph (A) of this paragraph, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(ii) The Commissioner may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this subsection.

(C) Each opinion required by subparagraph (B) of this paragraph shall be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the Commissioner as specified by regulation, shall be prepared to support each actuarial opinion; and

(ii) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by regulation or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(D) Every opinion required by this subsection shall be governed by the following provisions:

(i) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(ii) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by regulation;

(iii) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such

additional standards as the Commissioner may by regulation prescribe;

(iv) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(v) For the purposes of this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation;

(vi) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion;

(vii) Disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in regulations by the Commissioner;

(viii) Except as provided in divisions (xii), (xiii), and (xiv) of this subparagraph, documents, materials, or other information in the possession or control of the department that are a memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties;

(ix) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to division (viii) of this subparagraph;

(x) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(I) May share documents, materials, or other information, including the confidential and privileged documents, materi-

als, or information subject to division (viii) of this subparagraph with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, materials, or other information;

(II) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(III) May enter into agreements governing sharing and use of information consistent with divisions (viii) through (x) of this subparagraph;

(xi) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this subsection or as a result of sharing as authorized in division (x) of this subparagraph;

(xii) A memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this subsection or by regulations promulgated hereunder;

(xiii) The memorandum or other material may otherwise be released by the Commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material; and

(xiv) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state insurance department or

is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(2)(A) On and after the operative date of the valuation manual, every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the Commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(B) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the Commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subparagraph (A) of this paragraph, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(C) Each opinion required by subparagraph (B) of paragraph (2) of this subsection shall be governed by the following provisions:

(i) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the Commissioner, shall be prepared to support each actuarial opinion; and

(ii) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified in the valuation manual or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(D) Every opinion required by paragraph (2) of this subsection shall be governed by the following provisions:

(i) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commissioner;

(ii) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

(iii) The opinion shall apply to all policies and contracts subject to subparagraph (B) of paragraph (2) of this subsection, plus other actuarial liabilities as may be specified in the valuation manual;

(iv) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual;

(v) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(vi) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion; and

(vii) Disciplinary action by the Commissioner against the company or the appointed actuary shall be defined in regulations by the Commissioner.

(e)(1) Except as otherwise provided in paragraph (2) of this subsection and subsection (f) of this Code section, the minimum standards for the valuation of all life insurance policies and annuity or pure endowment contracts issued on or after January 1, 1966, shall be the Commissioner's reserve valuation methods defined in subsections (g), (h), and (i) of this Code section and the following interest rates and tables:

(A) Three and one-half percent interest or, in the case of policies and contracts other than annuity and pure endowment contracts issued on or after July 1, 1973, 4 percent interest for such policies issued prior to July 1, 1979, 5 1/2 percent interest for single premium life insurance policies, and 4 1/2 percent interest for all other such policies issued on or after July 1, 1979;

(B) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners 1958 Standard Ordinary Mortality Tables for such policies issued prior to the operative date of subsection (e) of Code Section 33-25-4 as amended, except that for any category of such policies issued on female risk modified net premiums and present values, referred to in subsection (g) of this Code section, may be calculated at the insurer's option and with the Commissioner's approval according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of subsection (e) of Code Section 33-25-4, (i) the Commissioners 1980 Standard Ordinary Mortality Table or, (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies;

(C) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table; for such policies issued prior to the date on which the Commissioners 1961 Standard Industrial Mortality Table becomes applicable in accordance with subsection (d) of Code Section 33-25-4 and for such policies issued on or after such date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies;

(D) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, ultimate, or any modification of either of these tables approved by the Commissioner;

(E) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the Commissioner or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(F) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued prior to January 1, 1966, either such tables or, at the option of the insurer, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(G) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies; for policies issued prior to January 1, 1966, either such table or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(H) For group life insurance, life insurance issued on the substandard basis, and other special benefits such tables or appropriate modifications of such tables as may be approved by the Commissioner as being sufficient with relation to the benefits provided by those policies.

(2) Except as provided in paragraphs (3) through (7) of this subsection, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph, as defined in this paragraph, and for all annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts, shall be the Commissioner's reserve valuation methods defined in subsections (g) and (h) of this Code section and the following tables and interest rates:

(A) For individual annuity and pure endowment contracts issued prior to July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any modification of this table approved by the Commissioner and 6 percent interest for single premium immedi-

ate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts;

(B) For individual single premium immediate annuity contracts issued on or after July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such contracts or any modification of these tables approved by the Commissioner and 7 1/2 percent interest;

(C) For individual annuity and pure endowment contracts issued on or after July 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such contracts or any modification of these tables approved by the Commissioner and 5 1/2 percent interest for single premium deferred annuity and pure endowment contracts and 4 1/2 percent interest for all other such individual annuity and pure endowment contracts;

(D) For all annuities and pure endowments purchased prior to July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any modification of this table approved by the Commissioner and 6 percent interest; and

(E) For all annuities and pure endowments purchased on or after July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments or any modification of these tables approved by the Commissioner and 7 1/2 percent interest.

After July 1, 1973, any insurer may file with the Commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1979, which shall be the operative

date of this paragraph for such insurer, provided that if an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(f)(1) The interest rates used in determining the minimum standard for the valuation of:

(A) All life insurance policies issued in a particular calendar year, on or after the operative date of subsection (e) of Code Section 33-25-4;

(B) All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1994;

(C) All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1994, under group annuity and pure endowment contracts; and

(D) The net increase, if any, in a particular calendar year after January 1, 1994, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in paragraphs (2) through (5) of this subsection.

(2) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of 1 percent:

(A) For life insurance:

$$I = .03 + W(R1 - .03) + 1/2\ W(R2 - .09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W(R - .03)$$

where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in paragraph (4) of this subsection, and W is the weighting factor defined in paragraph (3) of this subsection;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B) of this paragraph, the formula for life insurance stated in subparagraph (A) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply to annuities and

guaranteed interest contracts with guarantee duration of ten years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply;

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply;

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of 1 percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when subsection (e) of Code Section 33-25-4 becomes operative.

(3) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting Factors for Life Insurance:

Guarantee Duration Years	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80;

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B) of this paragraph, shall be as specified in Tables I, II, and III of this subparagraph, according to the rules and definitions in IV, V, and VI of this subparagraph:

I. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

II. For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Table I increased by:

Plan Type A	B	C
.15	.25	.05

III. For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in Table I or derived in Table II increased by:

	Plan Type		
	A	B	C
	.05	.05	.05

IV. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence;

V. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) without such adjustment but in installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted;

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years;

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund;

VI. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the

annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(4) The reference interest rate referred to in paragraph (2) of this subsection shall be defined as follows:

(A) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published in Moody's Investors Service, Inc.;

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subparagraph (B) of this paragraph, with guarantee duration in excess of ten years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subparagraph (B) of this paragraph, with guarantee duration of ten years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the

calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.; and

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subparagraph (B) of this paragraph, the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(5) In the event that Moody's Corporate Bond Yield Average — Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or, in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average — Monthly Average Corporates as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then the alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commissioner, may be substituted.

(g)(1) Except as otherwise provided in subsections (l) and (n) of this Code section, reserves according to the Commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value at the date of valuation of the future guaranteed benefits provided for by the policies over the then present value of any future modified net premiums therefor. The modified net premiums for the policy shall be the uniform percentage of the respective contract premiums for the benefits, excluding extra premiums on a substandard policy, that the present value at the date of issue of the policy of all the modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of subparagraph (A) of this paragraph over subparagraph (B) of this paragraph as follows:

(A) A net level annual premium equal to the present value at the date of issue of such benefits provided for after the first policy year, divided by the present value at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that the net level annual premium shall not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy; and

(B) A net one-year term premium for the benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after the effective date of subsection (h) of Code Section 33-25-4 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the Commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined in this subsection as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (l) of this Code section, be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in subparagraph (A) of that paragraph being reduced by 15 percent of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subsections (e) and (f) of this Code section shall be used.

(2) Reserves according to the Commissioner's reserve valuation method for:

(A) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(B) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code as now or hereafter amended;

(C) Disability and accidental death benefits in all policies and contracts; and

(D) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection.

(h) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code. Reserves according to the Commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values at the date of valuation of the future guaranteed benefits, including guaranteed nonforfeiture benefits provided for by the contracts at the end of each respective contract year, over the present value at the date of valuation of any future valuation considerations derived from future gross considerations required by the terms of the contract that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(i) In no event shall an insurer's aggregate reserve for all life insurance policies, excluding disability and accidental death benefits issued on or after January 1, 1966, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (g), (h), (l), and (m) of this Code section and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies. In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by subsection (d) of the Code section.

(j)(1) Reserves for all policies and contracts issued prior to January 1, 1966, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all the policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date.

(2) For any category of policies, contracts, or benefits specified in subsection (e) of this Code section issued on or after January 1, 1966, reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard provided in this Code section; but the rate or rates of interest used for policies and contracts, other than annuity and pure

endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies and contracts.

(k) An insurer that at any time had adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided for in subsection (i) of this Code section may, with the approval of the Commissioner, adopt any lower standard of valuation but not lower than the minimum provided in this subsection; provided, however, that for the purposes of this subsection, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by subsection (d) of this Code section shall not be deemed to be the adoption of a higher standard of valuation.

(l) If in any contract year the gross premium charged by any life insurer on any policy or contract issued on or after January 1, 1966, is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this Code section are those standards stated in subsections (e) and (f) of this Code section. Provided that for any life insurance policy issued on or after the effective date of subsection (h) of Code Section 33-25-4 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides as an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (g) of this Code section, ignoring the second paragraph of paragraph (1) of subsection (g) of this Code section. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (g) of this Code section, including the second paragraph of paragraph (1) of subsection (g) of this Code section, and the minimum reserve calculated in accordance with this subsection.

(m) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by

the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (e), (g), (h), and (l) of this Code section, the reserves which are held under any such plan must:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method which is consistent with the principles of this Code section, the "Standard Valuation Law,"

as determined by regulations promulgated by the Commissioner.

(n) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph (2) of subsection (c) of this Code section. For disability, accident and sickness, accident, and health insurance contracts issued prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the Commissioner by regulation.

(o)(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph (2) of subsection (c) of this Code section, except as provided under paragraphs (5) and (7) of this subsection.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(A) The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater;

(B) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75 percent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements; and

(C) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: The 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(A) At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership; and

(B) Members of the NAIC representing jurisdictions totaling greater than 75 percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subparagraph (A) of this paragraph: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(4) The valuation manual must specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to paragraph (2) of subsection (c) of this Code section. Such minimum valuation standards shall be:

(i) The Commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to paragraph (2) of subsection (c) of this Code section;

(ii) The Commissioner's annuity reserve valuation method for annuity contracts subject to paragraph (2) of subsection (c) of this Code section; and

(iii) Minimum reserves for all other policies or contracts subject to paragraph (2) of subsection (c) of this Code section;

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in paragraph (1) of subsection (p) of this Code section and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (p) of this Code section:

(i) Requirements for the format of reports to the Commissioner under subparagraph (p)(2)(C) of this Code section and which shall include information necessary to determine if the valuation is appropriate and in compliance with this Code section;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence; and

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(D) For policies not subject to a principle-based valuation under subsection (p) of this Code section the minimum valuation standard shall either:

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(E) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(F) The data and form of the data required under subsection (q) of this Code section, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commissioner, in compliance with this Code section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the Commissioner by regulation.

(6) The Commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this Code section. The Commissioner may rely upon the opinion, regarding provisions contained within this Code section, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(7) The Commissioner may require a company to change any assumption or method that in the opinion of the Commissioner is necessary in order to comply with the requirements of the valuation manual or this Code section; and the company shall adjust the reserves as required by the Commissioner. The Commissioner may take other disciplinary action as permitted pursuant to this title.

(p)(1) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(A) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

(B) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(C) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual; or

(ii) For assumptions that are not prescribed, the assumptions shall:

(I) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(II) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience; and

(D) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall:

(A) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(B) Provide to the Commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accor-

dance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year; and

(C) Develop, and file with the Commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic reserve component.

(q) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(r)(1) For purposes of this subsection, the term "confidential information" shall mean:

(A) A memorandum in support of an opinion submitted under subsection (d) of this Code section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such memorandum;

(B) All documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under paragraph (6) of subsection (o) of this Code section; provided, however, that if an examination report or other material prepared in connection with an examination made under Chapter 2 of this title is not held as private and confidential information under Chapter 2 of this title, an examination report or other material prepared in connection with an examination made under paragraph (6) of subsection (o) of this Code section shall not be confidential information to the same extent as if such examination report or other material had been prepared under Chapter 2 of this title;

(C) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under subparagraph (p)(2)(B) of this Code section evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such reports, documents, materials, and other information;

(D) Any principle-based valuation report developed under subparagraph (p)(2)(C) of this Code section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such report; and

(E) Any documents, materials, data, and other information submitted by a company under subsection (q) of this Code section (collectively, "experience data") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the Commissioner (together with any "experience data," the "experience materials") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such experience materials.

(2)(A) Except as provided in this subsection, a company's confidential information is confidential by law and privileged, and shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the Commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the Commissioner's official duties.

(B) Neither the Commissioner nor any person who received confidential information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(C) In order to assist in the performance of the Commissioner's duties, the Commissioner may share confidential information (i) with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries, and (ii) in the case of confidential information specified in subparagraphs (A) and (D) of paragraph (1) of this subsection only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; in the case of (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in

the same manner and to the same extent as required for the Commissioner.

(D) The Commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(E) The Commissioner may enter into agreements governing sharing and use of information consistent with this paragraph.

(F) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the Commissioner under this subsection or as a result of sharing as authorized in subparagraph (C) of paragraph (2) of this subsection.

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this paragraph shall be available and enforced in any proceeding in, and in any court of, this state.

(H) In this subsection, the terms "regulatory agency," "law enforcement agency," and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(3) Notwithstanding this paragraph, any confidential information specified in subparagraphs (A) and (D) of paragraph (1) of this subsection:

(A) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (d) of this Code section or principle-based valuation report developed under subparagraph (p)(2)(C) of this Code section by reason of an action required by this Code section or by regulations promulgated hereunder;

(B) May otherwise be released by the Commissioner with the written consent of the company; and

(C) Once any portion of a memorandum in support of an opinion submitted under subsection (d) of this Code section or a

principle-based valuation report developed under subparagraph (p)(2)(C) of this Code section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

(s)(1) The Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of subsection (o) of this Code section, provided:

(A) The Commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(B) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the Commissioner and promulgated by regulation.

(2) For any company granted an exemption under this subsection, subsections (d) through (n) of this Code section shall be applicable. With respect to any company applying this exemption, any reference to subsection (o) of this Code section in subsections (d) through (n) of this Code section shall not be applicable.

(t)(1) An insurer that has less than $300 million of ordinary life premiums and that is licensed and doing business in this state and that is subject to the requirements of subsections (o) through (r) of this Code section is deemed to pass the exclusion tests associated with life insurance reserve requirements incorporated in the valuation manual, provided that:

(A) If the insurer is a member of a group of life insurers, the group has combined ordinary life premiums of less than $600 million;

(B) The insurer reported total adjusted capital of at least 450 percent of authorized control level risk based capital in the risk based capital report for the prior calendar year;

(C) The appointed actuary has provided an unqualified opinion on the reserves for the prior calendar year; and

(D) The insurer has provided a certification by a qualified actuary that any universal life policy with a secondary guarantee issued by the insurer after the operative date of the valuation manual meets the definition of a nonmaterial secondary guarantee universal life product as defined in the valuation manual.

(2) For purposes of paragraph (1) of this subsection, ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the annual statement for the prior calendar year.

(3) A company that meets the requirements under paragraph (1) of this subsection is also subject to the requirements of subsection (l) of this Code section.

(4) A domestic company meeting all of the conditions provided in this subsection may file, prior to July 1 of the current calendar year, a statement with the Commissioner certifying that such conditions are met for the current calendar year based on premiums and other values from the financial statements for the prior calendar year. The Commissioner may reject such statement prior to September 1 and require a company to comply with the valuation manual requirements for life insurance reserves. (Code 1981, § 33-10-13, enacted by Ga. L. 2015, p. 846, § 1/HB 185.)

Effective date. — This Code section became effective July 1, 2015.

Editor's notes. — This Code section formerly pertained to valuation of reserves. The former Code section was based on Code 1933, § 56-912, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 487, § 1; Ga. L. 1973, p. 617, § 1; Ga. L. 1979, p. 1407, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 650, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1993, p. 483, §§ 1-5 and was repealed by Ga. L. 2015, p. 846, § 1/HB 185, effective July 1, 2015.

CHAPTER 13

INSURANCE HOLDING COMPANY SYSTEMS

Article 1

General Provisions

ARTICLE 1

GENERAL PROVISIONS

Editor's notes. — Ga. L. 2015, p. 608, § 1/SB 108, designated §§ 33-13-1 through 33-13-15 as Article 1.

33-13-1. Definitions.

As used in this article, the term:

(1) "Affiliate," including the term "affiliate of" or "person affiliated with" a specific person, means a person who directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the person specified.

(2) "Commissioner" means the Commissioner of Insurance, the Commissioner's deputies, or the Insurance Department, as appropriate.

(3) "Control," including the terms "controlling," "controlled by," and "under common control with," means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office held by the person. Control shall be presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection (k) of Code Section 33-13-4 that control does not exist in fact. The Commissioner may determine after furnishing all persons in interest notice and opportunity to be heard and after making specific findings of fact to support such determination that

control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in Chapter 56 of this title or would cause the insurer to be in hazardous financial condition based on the standards prescribed by Chapter 120-2-54 of the Commissioner's rules and regulations.

(5) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(6) "Insurer" shall have the same meaning as set forth in Code Section 33-1-2, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(7) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(8) "Subsidiary" means an affiliate controlled by a specified person directly or indirectly through one or more intermediaries.

(9) "Voting security" shall include any security convertible into or evidencing a right to acquire a voting security. (Code 1933, § 56-3401, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" in the introductory paragraph of this Code section.

33-13-4. Registration of insurers belonging to holding company systems.

(a) **Requirement of registration generally.** Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to disclosure requirements and

standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained:

(1) In this Code section;

(2) In paragraph (1) of subsection (a), subsection (b), and subsection (d) of Code Section 33-13-5; and

(3) In either paragraph (2) of subsection (a) of Code Section 33-13-5 or a provision such as the following: "Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition."

Any insurer which is subject to registration under this Code section shall register within 15 days after it becomes subject to registration and annually thereafter by April 30 of each year for the previous calendar year, unless the Commissioner for good cause shown extends the time for registration, and then within the extended time. The Commissioner may require any insurer authorized to do business in this state which is a member of an insurance holding company system, and which is not subject to registration under this Code section, to furnish a copy of the registration statement, the summary specified in subsection (c) of this Code section, or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

(b) **Contents of registration statement.** Every insurer subject to registration shall file a registration statement with the Commissioner on a form and in a format prescribed by the National Association of Insurance Commissioners, which statement shall contain current information about:

(1) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(2) The identity of every member of the insurance holding company system;

(3) The following agreements in force, relationships subsisting, and transactions currently outstanding between such insurer and its affiliates:

(A) Loans, other investments, or purchases, sales, or exchanges of the affiliates by the insurer or of the insurer by its affiliates;

(B) Purchases, sales, or exchanges of assets;

(C) Transactions not in the ordinary course of business;

(D) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's

assets to liability other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) All management and service contracts and all cost-sharing arrangements;

(F) Reinsurance agreements;

(G) Dividends and other distributions to shareholders; and

(H) Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the Commissioner, financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the federal Securities and Exchange Commission pursuant to the federal Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the Securities and Exchange Commission;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner;

(7) Statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the Commissioner by rule or regulation.

(c) **Summary of changes to registration statement.** All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) **Disclosure of nonmaterial information.** No information need be disclosed on the registration statement filed pursuant to subsection (b) of this Code section if the information is not material for the purposes of this Code section. Unless the Commissioner by rule, regulation, or order provides otherwise, sales, purchases, exchanges, loans, extensions of credit, or investments involving one-half of 1

percent or less of an insurer's admitted assets as of December 31 of the preceding year shall not be deemed material for purposes of this Code section.

(e) **Reporting dividends to shareholders.** Subject to subsection (b) of Code Section 33-13-5, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within 15 business days following the declaration thereof.

(f) **Information of insurers.** Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this article.

(g) **Termination of registration.** The Commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(h) **Filing of consolidated registration.** The Commissioner may require or allow two or more affiliated insurers subject to registration under this Code section to file a consolidated registration statement.

(i) **Filing of registration for affiliated insurer.** The Commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) of this Code section and to file all information and material required to be filed under this Code section.

(j) **Exemptions.** This Code section shall not apply to any insurer, information, or transaction if and to the extent that the Commissioner by rule, regulation, or order shall exempt the same from this Code section.

(k) **Filing of disclaimer.** Any person may file with the Commissioner a disclaimer of affiliation with any authorized insurer or the disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the persons and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the Commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this Code section if approval of the disclaimer has been granted by the Commissioner, or if the disclaimer is deemed to have been approved.

(l) **Enterprise risk filing.** The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(m) **Violations.** The failure to file a registration statement or any amendment to the registration statement required by this Code section within the time specified for the filing shall be a violation of this Code section. (Code 1933, § 56-3404, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1993, p. 625, § 1; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" at the end of subsection (f).

33-13-5. Standards governing transactions by registered insurers with affiliates generally; extraordinary distributions; adequacy of surplus.

(a)(1) Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) Agreements for cost sharing services and management shall include such provisions as required by the Commissioner by rule or regulation;

(C) Charges or fees for services performed shall be reasonable;

(D) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(E) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(F) The insurer's surplus with regard to policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this Code section, which are subject to any materiality standards contained in subparagraphs (A) through (G) of this paragraph, may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto, or such shorter period as the Commissioner may permit, and the Commissioner has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the Commissioner for determination of the type of filing required, if any:

(A) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided such transactions are equal to or exceed: with respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders; or with respect to life insurers, 3 percent of the insurer's admitted assets; each as of December 31 next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in any affiliate of the insurer making such loans or extensions of credit to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided such transactions are equal to or exceed: with respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus with regard to policyholders; or with respect to life insurers, 3 percent of the insurer's admitted assets; each as of December 31 next preceding;

(C) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements; and

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds 5 percent of the insurer's surplus with regard to policyholders, as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and

nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(D) All management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing agreements;

(E) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of 1 percent of the insurer's admitted assets or 10 percent of surplus as regards policyholders as of December 31 next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(F) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an agreement which, together with its present holdings in such investments, exceeds 2 1/2 percent of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Code Section 33-13-2 or authorized under any other Code section of this title, or in nonsubsidiary insurance affiliates that are subject to the provisions of this article, are exempt from this requirement; and

(G) Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing contained in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer that is not a member of the same holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the Commissioner determines that such separate transactions were entered into over any 12 month period for such purpose, the Commissioner may exercise his or her authority under Code Section 33-13-11.

(4) The Commissioner, in reviewing transactions pursuant to paragraph (2) of this subsection, shall consider whether the transactions comply with the standards set forth in paragraph (1) of this subsection and whether they may adversely affect the interests of policyholders.

(5) The Commissioner shall be notified within 30 days of any investment of the domestic insurer in any one corporation if the total

investment in such corporation by the insurance holding company system exceeds 10 percent of such corporation's voting securities.

(b)(1) No domestic insurer shall apply any extraordinary dividend or make any other extraordinary distribution to its shareholders until 30 days after the Commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or until the Commissioner has approved such payment within such 30 day period.

(2) For the purposes of this subsection, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the lesser of 10 percent of such insurer's surplus with regard to policyholders as of December 31 next preceding, or the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the 12 month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

(3) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(4) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until the Commissioner has approved the payment of such a dividend or distribution or the Commissioner has not disapproved such payment within the 30 day period referred to in paragraph (1) of this subsection.

(c) For purposes of this article, in determining whether an insurer's surplus with regard to policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification, and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) The surplus with regard to policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus with regard to policyholders whenever in the judgment of the Commissioner the investment so warrants. (Code 1933, § 56-3405, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1975, p. 1238, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1991, p. 1424, § 6; Ga. L. 1993, p. 625, § 2; Ga. L. 2000, p. 136, § 33; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" in subparagraph (a)(2)(F) and near the beginning of subsection (c).

33-13-6. Powers of Commissioner to examine insurers; access to books and records; use of experts and consultants; payment of expenses; compelling production.

(a) **Powers of Commissioner.** Subject to the limitation contained in this Code section and in addition to the powers which the Commissioner has under this title relating to the examination of insurers, the Commissioner shall have the power to examine any insurer registered under Code Section 33-13-4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) **Access to books and records.**

(1) The Commissioner may order any insurer registered under Code Section 33-13-4 to produce such records, books, or other information in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this article.

(2) To determine compliance with this article, the Commissioner may order any insurer registered under Code Section 33-13-4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of $1,000.00 for each day's delay, or may suspend or revoke the insurer's license.

(c) **Use of consultants.** The Commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection (a) of this Code section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(d) **Expenses.** Each registered insurer producing for examination records, books, and papers pursuant to subsection (a) of this Code section shall be liable for and shall pay the expense of the examination in accordance with Code Section 33-2-15.

(e) **Compelling production.** In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this subsection. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in superior court, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined. (Code 1933, § 56-3406, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1992, p. 2725, § 18; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" at the end of paragraph (b)(1) and the beginning of paragraph (b)(2).

33-13-8. Confidentiality of information and documents obtained during examinations or investigations; sharing certain information; not delegation of regulatory authority or rule making; responsibility for enforcement.

(a) Documents, materials, or other information in the possession or control of the department that are obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to Code Section 33-13-6 and all information reported pursuant to paragraphs (12) and (13) of subsection (b) of Code Section 33-13-3, Code Section 33-13-4, and Code Section 33-13-5 shall be confidential by law and privileged, shall not be subject to public disclosure under Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which it pertains unless the Commissioner, after giving the insurer and its affiliates that would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the Commissioner may publish all or any part in such manner as may be deemed appropriate.

(b) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information subject to subsection (a) of this Code section.

(c) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to subsection (a) of this Code section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in Code Section 33-13-7, provided that the recipient agrees

in writing to maintain the confidentiality and privileged status of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) Notwithstanding paragraph (1) of this subsection, may only share confidential and privileged documents, materials, or other information reported pursuant to subsection (l) of Code Section 33-13-4 with commissioners of states having statutes or regulations substantially similar to subsection (a) of this Code section and who have agreed in writing not to disclose such information;

(3) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; and

(4) Shall enter into written agreements with the National Association of Insurance Commissioners governing sharing and use of information provided pursuant to this article consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, and international regulatory agencies;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article remains with the Commissioner and that the National Association of Insurance Commissioners' use of the information is subject to the direction of the Commissioner;

(C) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners pursuant to this article is subject to a request or subpoena to the National Association of Insurance Commissioners for disclosure or production; and

(D) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by

an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article.

(d) The sharing of information by the Commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rule making, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this Code section or as a result of sharing as authorized in subsection (c) of this Code section.

(f) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners pursuant to this article shall be confidential by law and privileged, shall not be subject to the open records laws, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. (Code 1933, § 56-3407, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-7; Code 1981, § 33-13-8, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" throughout this Code section.

33-13-9. Rules and regulations and orders.

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue any rules, regulations, and orders as shall be necessary to carry out this article. (Code 1933, § 56-3408, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-8; Code 1981, § 33-13-9, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" at the end of this Code section.

33-13-10. Injunctions; seizure or sequestration of voting securities.

(a) **Injunctions.** Whenever it appears to the Commissioner that any insurer or any director, officer, employee, or agent of any insurer has committed or is about to commit a violation of this article or of any rule,

regulation, or order issued by the Commissioner under this article, the Commissioner may apply to the superior court of the county in which the principal office of the insurer is located or, if the insurer has no such office in this state, to the Superior Court of Fulton County for an order enjoining the insurer or the director, officer, employee, or agent of such insurer from violating or continuing to violate this article or any rule, regulation, or order and for any other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

(b) **Voting of securities; when prohibited.** No security which is the subject of any agreement or arrangement regarding acquisition or which is acquired or to be acquired in contravention of this article or of any rule, regulation, or order issued by the Commissioner under this article may be voted at any shareholders' meeting or counted for quorum purposes; and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the Commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of this article or of any rule, regulation, or order issued by the Commissioner under this article, the insurer or the Commissioner may apply to the Superior Court of Fulton County or to the superior court of the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of Code Section 33-13-3 or any rule, regulation, or order issued by the Commissioner under Code Section 33-13-3 to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders, and for any other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

(c) **Sequestration of voting securities.** In any case in which a person has acquired or is proposing to acquire any voting securities in violation of this article or any rule, regulation, or order issued by the Commissioner under this article, the Superior Court of Fulton County or the superior court of the county in which the insurer has its principal place of business, on any notice as the court deems appropriate and upon the application of the insurer or the Commissioner, may seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue such orders with respect to the seizure or sequestration as may be appropriate to effectuate this article. Notwithstanding any other provisions of law, for the purposes of this article the situs of the ownership of the securities of domestic insurers shall be

deemed to be in this state. (Code 1933, § 56-3409, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-9; Code 1981, § 33-13-10, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" throughout this Code section.

33-13-11. Violations of this article.

(a) Any insurer failing, without just cause, to file any registration statement as required in this article shall be required, after notice and hearing, to pay a penalty of $1,000.00 for each day's delay. The maximum penalty under this Code section is $50,000.00. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to subsection (a) of Code Section 33-13-4, paragraph (2) of subsection (a) of Code Section 33-13-5, or subsection (b) of Code Section 33-13-5, or which violate this article, shall pay, in their individual capacity, a civil forfeiture of not more than $50,000.00 per violation, after notice and hearing before the Commissioner. In determining the amount of the civil forfeiture, the Commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(c) Whenever it appears to the Commissioner that any insurer subject to this article or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which is subject to Code Section 33-13-5 and which would not have been approved had the approval been requested, the Commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the Commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of its policyholders, creditors, or the public.

(d) Whenever it appears to the Commissioner that any insurer or any director, officer, employee, or agent thereof has committed a willful violation of this article, the Commissioner may cause criminal proceedings to be instituted by the Superior Court of Fulton County against the

insurer or the responsible director, officer, employee, or agent thereof. Any insurer which willfully violates this article may be fined not more than $100,000.00. Any individual who willfully violates this article may be fined in his or her individual capacity not more than $100,000.00 or be imprisoned for not more than one to three years, or both.

(e) Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the Commissioner in the performance of his or her duties under this article upon conviction shall be imprisoned for not more than three years or fined $100,000.00, or both. Any fines imposed shall be paid by the officer, director, or employee in his or her individual capacity.

(f) Whenever it appears to the Commissioner that any person has committed a violation of Code Section 33-13-3 and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Code Section 33-3-18. (Code 1981, § 33-13-11, enacted by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" throughout this Code section.

33-13-12. Receivership.

Whenever it appears to the Commissioner that any person has committed a violation of this article which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, the Commissioner may proceed as provided in Chapter 37 of this title to take possession of the property of the domestic insurer and to conduct the business of the domestic insurer. (Code 1933, § 56-3411, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-11; Code 1981, § 33-13-12, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" near the beginning of this Code section.

33-13-13. Revocation, suspension, or nonrenewal of license or authority to do business.

Whenever it appears to the Commissioner that any person has committed a violation of this article which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for any period as he or she finds is required for the protection of policyholders or the public. Any determination shall be accompanied by specific findings of fact and conclusions of law. (Code 1933, § 56-3412, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-12; Code 1981, § 33-13-13, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" near the beginning of this Code section.

33-13-15. Aggrieved persons; appeal of actions of Commissioner; mandamus.

(a) Any person aggrieved by any act, determination, rule, regulation, or order or any other action of the Commissioner pursuant to this article may appeal the action to the Superior Court of Fulton County. The court shall conduct its review without a jury and by trial de novo, except that, if all parties including the Commissioner so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

(b) The filing of an appeal pursuant to this Code section shall stay the application of any such rule, regulation, order, or other action of the Commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that such a stay would be detrimental to the interests of policyholders, shareholders, creditors, or the public.

(c) Any person aggrieved by any failure of the Commissioner to act or make a determination required by this article may petition the Superior Court of Fulton County for a writ in the nature of a mandamus or a peremptory mandamus directing the Commissioner to act or make the determination immediately. (Code 1933, § 56-3413, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Code 1981, § 33-13-14; Code 1981, § 33-13-15, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.)

The 2015 amendment, effective July 1, 2015, substituted "this article" for "this chapter" in the first sentence of subsection (a) and near the beginning of subsection (c).

ARTICLE 2

OWN RISK AND SOLVENCY ASSESSMENT REPORT

Effective date. — This article became effective July 1, 2015.

33-13-30. Confidential and sensitive information within Own Risk and Solvency Assessment Summary Report; legislative intent.

(a) The General Assembly finds and declares that an Own Risk and Solvency Assessment Summary Report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public.

(b) It is the intent of the General Assembly that the Own Risk and Solvency Assessment Summary Report shall be a confidential document filed with the Commissioner, that the Own Risk and Solvency Assessment Summary Report will be shared only as stated in this article and to assist the Commissioner in the performance of his or her duties, and that in no event shall the Own Risk and Solvency Assessment Summary Report be subject to public disclosure. (Code 1981, § 33-13-30, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-31. Purpose.

The purpose of this article is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment and provide guidance and instructions for filing an Own Risk and Solvency Assessment Summary Report with the Commissioner. The requirements of this article shall apply to all insurers domiciled in this state unless exempt pursuant to Code Section 33-13-36. (Code 1981, § 33-13-31, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-32. Definitions.

As used in this chapter, the term:

(1) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in paragraph (5) of Code Section 33-13-1.

(2) "Insurer" shall have the same meaning as set forth in Code Section 33-1-2, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(3) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(4) "ORSA Guidance Manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on January 1 following the calendar year in which the changes have been adopted by the National Association of Insurance Commissioners.

(5) "ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA. (Code 1981, § 33-13-32, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-33. Maintenance of risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer. (Code 1981, § 33-13-33, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-34. Required conduct of ORSA.

Subject to Code Section 33-13-36, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member. (Code 1981, § 33-13-34, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-35. Submission of ORSA Summary Report.

(a) Upon the Commissioner's request, and no more than once each year, an insurer shall submit to the Commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer or the insurance group of which it is a member. Notwithstanding any request from the Commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report or reports required by this subsection if the Commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The report or reports shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee.

(c) An insurer may comply with subsection (a) of this Code section by providing the most recent and substantially similar report or reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language. (Code 1981, § 33-13-35, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-36. Exemption.

(a) An insurer shall be exempt from the requirements of this article, if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500 million; and

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums

reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1 billion.

(b) If an insurer qualifies for exemption pursuant to paragraph (1) of subsection (a) of this Code section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (2) of subsection (a) of this Code section, then the ORSA Summary Report that may be required pursuant to Code Section 33-13-35 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers, provided that any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to paragraph (1) of subsection (a) of this Code section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (2) of subsection (a) of this Code section, then the only ORSA Summary Report that may be required pursuant Code Section 33-13-35 shall be the report applicable to that insurer.

(d) An insurer that does not qualify for exemption pursuant to subsection (a) of this Code section may apply to the Commissioner for a waiver from the requirements of this article based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the Commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the Commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the Commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this Code section:

(1) The Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; and

(2) The Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report if the insurer has risk-based capital for company action level event as set forth in Chapter 56 of this title, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as provided for pursuant to Commissioner's rules

and regulations, or otherwise exhibits qualities of a troubled insurer as determined by the Commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) of this Code section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year following the year the threshold is exceeded to comply with the requirements of this article. (Code 1981, § 33-13-36, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-37. Preparation of report; review and use.

(a) The ORSA Summary Report shall be prepared consistently with the ORSA Guidance Manual, subject to the requirements of subsection (b) of this Code section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

(b) The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups. (Code 1981, § 33-13-37, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-38. Confidentiality and protection.

(a) Documents, materials, or other information, including the ORSA Summary Report, in the possession of or control of the Insurance Department that are obtained by, created by, or disclosed to the Commissioner or any other person under this article, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(b) Neither the Commissioner nor any person who received documents, materials, or other ORSA related information, through examination or otherwise, while acting under the authority of the Commissioner or with whom such documents, materials, or other information

are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this Code section.

(c) In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

(1) May upon request share documents, materials, or other ORSA related information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this Code section, including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in Code Section 33-13-7, with the National Association of Insurance Commissioners and with any third-party consultants designated by the Commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) May receive documents, materials or other ORSA related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in Code Section 33-13-7, and from the National Association of Insurance Commissioners, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to this article, consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article remains with the Commissioner and the National Association of Insurance Commissioners's or a third-party consultant's use of the information is subject to the direction of the Commissioner;

(C) Prohibit the National Association of Insurance Commissioners or third-party consultant from storing the information shared pursuant to this article in a permanent data base after the underlying analysis is completed;

(D) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production;

(E) Require the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article; and

(F) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the Commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other ORSA related information shall occur as a result of disclosure of such ORSA related information or documents to the Commissioner under this Code section or as a result of sharing as authorized in this article.

(f) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. (Code 1981, § 33-13-38, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-39. Penalty for noncompliance.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this article may be subject to any penalty set forth in subsection (g) of Code Section 33-2-24. The Commissioner may reduce the monetary penalty if the insurer demonstrates to the Commissioner that the imposition of the monetary penalty would constitute a financial hardship to the insurer. (Code 1981, § 33-13-39, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-40. Severability.

If any provision of this article, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this article which can be given effect without the invalid provision or application, and to that end the provisions of this article are severable. (Code 1981, § 33-13-40, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

33-13-41. Effective date for compliance.

The requirements of this article shall become effective on July 1, 2015. The first filing of the ORSA Summary Report shall be required in 2015 pursuant to Code Section 33-13-35. (Code 1981, § 33-13-41, enacted by Ga. L. 2015, p. 608, § 2/SB 108.)

CHAPTER 13A

MUTUAL INSURANCE HOLDING COMPANIES

Effective date. — This chapter became effective July 1, 2015.

33-13A-1. Short title.

This chapter shall be known and may be cited as the "Mutual Insurance Holding Company Act." (Code 1981, § 33-13A-1, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-2. Definitions.

As used in this chapter, the term:

(1) "Intermediate stock holding company" means one or more stock corporations that own all of the shares of voting stock of one or more reorganized stock insurers after a reorganization under Code Section 33-13A-3 or a merger under Code Section 33-13A-4.

(2) "Majority of the voting stock of the reorganized stock insurer" means shares of the capital stock of the reorganized stock insurer that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized stock insurer for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized stock insurer. The ownership of a majority of the voting stock of the reorganized stock insurer that is required pursuant to this chapter to be at all times owned by a mutual insurance holding company includes indirect ownership through one or more intermediate stock holding companies in a corporate structure approved by the Commissioner. However, indirect ownership through one or more intermediate stock holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting stock of the reorganized stock insurer. The Commissioner shall have jurisdiction over an intermediate stock holding company as if it were a mutual insurance holding company.

(3) "Member" means a person who obtains a membership interest in a mutual insurance holding company by virtue of being a policyholder of a mutual insurer that is the subject of a reorganization plan under Code Section 33-13A-3 or a merger plan under Code Section 33-13A-4.

(4) "Merger plan" means a plan approved by a mutual insurer's board of directors under Code Section 33-13A-4 which proposes to merge a domestic or foreign mutual insurer into an existing mutual insurance holding company or into an intermediate stock holding company, thereby converting the domestic or foreign mutual insurer into a stock insurer.

(5) "Mutual insurance holding company" means a domestic corporation incorporated pursuant to a reorganization plan under Code

Section 33-13A-3 or a merger plan under Code Section 33-13A-4, which company is the ultimate parent of a reorganized stock insurer and which may be the parent company of one or more intermediate stock holding companies.

(6) "Policyholder" means a person who is insured under one or more insurance policies or annuity contracts by a mutual insurer at the time of a reorganization under Code Section 33-13A-3 or a merger under Code Section 33-13A-4.

(7) "Reorganization plan" means a reorganization plan adopted by a mutual insurer's board of directors in accordance with Code Section 33-13A-3 or 33-13A-4 which proposes to convert the domestic or foreign mutual insurer into a stock insurer.

(8) "Reorganized stock insurer" means the domestic or foreign stock insurer resulting from a domestic or foreign mutual insurer's reorganization under Code Section 33-13A-3 or merger under Code Section 33-13A-4.

(9) "Voting stock" means securities of any class or any ownership interest having voting power for the election of directors, trustees, or management of a corporation. Voting stock shall also mean any security convertible into or evidencing a right to acquire a voting security. (Code 1981, § 33-13A-2, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-3. Reorganization plans.

(a) A domestic mutual insurer, upon approval of the Commissioner, may reorganize by forming an insurance holding company system, which shall be designated as a mutual insurance holding company, based upon a reorganization plan and continuing the corporate existence of the reorganizing insurer as a stock insurer. Such a reorganization plan must be adopted by the affirmative vote of not less than two-thirds of the mutual insurer's board of directors. The Commissioner, after a public hearing as provided in paragraph (2) of subsection (d) of Code Section 33-13-3, if satisfied that the interests of the policyholders are properly protected and that the reorganization plan is fair and equitable to the policyholders, may approve the proposed reorganization plan and may require as a condition of approval such modifications of the reorganization plan as the Commissioner finds necessary for the protection of the policyholders' interests. A reorganization pursuant to this Code section is subject to the requirements of Code Section 33-13-3. The Commissioner shall retain jurisdiction over a mutual insurance holding company organized pursuant to this Code section to ensure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company

or to an intermediate stock holding company. The membership interests of the policyholders of the reorganized stock insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized stock insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or an intermediate stock holding company.

(c) The reorganization plan shall provide that all of the initial shares of capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company or to an intermediate stock holding company. The reorganization plan shall provide that the mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or, alternatively, that the mutual insurance holding company shall at all times own the majority of voting stock in an intermediate stock holding company, which intermediate stock holding company shall at all times own all of the voting stock of the reorganized stock insurer. The shares of voting stock required to be owned by the mutual insurance holding company or by an intermediate stock holding company shall not be pledged, hypothecated, or in any way encumbered with regard to any obligation, guaranty, or commitment undertaken by or on behalf of the mutual insurance holding company or the intermediate stock holding company, if any. The reorganization plan shall also provide that the board of directors of the mutual insurance holding company will be elected by the members.

(d) The reorganization plan shall provide that membership interests of the policyholders of the mutual insurer shall automatically convert to membership interests in the mutual insurance holding company so long as the policy is in force as of the date the reorganization plan was adopted by the board of directors of the mutual insurer and that, concurrently upon the effective date of the reorganization, the policyholder's membership interests in the mutual insurer shall be extinguished. (Code 1981, § 33-13A-3, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-4. Procedure for reorganization.

(a) A domestic mutual insurer, upon the approval of the Commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to Code Section 33-13A-3 and continuing the corporate existence of the reorganizing insurer as a stock insurer subsidiary of the mutual insurance holding company or an intermediate stock holding company. The Commissioner, after a public hearing as provided in paragraph (2) of

subsection (d) of Code Section 33-13-3, if satisfied that the interests of the policyholders are properly protected and that the merger plan is fair and equitable to the policyholders, may approve the merger plan and may require as a condition of approval such modifications of the merger plan as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner shall retain jurisdiction over the mutual insurance holding company organized pursuant to this Code section to ensure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company or to an intermediate stock holding company. The membership interests of the policyholders of the reorganized stock insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized stock insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or an intermediate stock holding company. A merger of policyholders' membership interests in a mutual insurer into a mutual insurance holding company shall be deemed to be the acquisition of an insurance control company pursuant to Code Section 33-13-3 and is subject to the requirements of Code Section 33-13-3.

(c) A foreign mutual insurer which, if a domestic mutual insurer, would be organized under Chapter 14 of this title may reorganize upon the approval of the Commissioner and in compliance with the requirements of any law or rule applicable to the foreign mutual insurer by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to Code Section 33-13A-3 and continuing the corporate existence of the reorganizing foreign mutual insurer as a foreign stock insurer subsidiary of the mutual insurance holding company or one or more intermediate stock holding companies. The Commissioner, after a public hearing as provided in paragraph (2) of subsection (d) of Code Section 33-13-3, may approve the proposed merger. The reorganizing foreign mutual insurer may remain a foreign company or foreign corporation after the merger and may be admitted to do business in this state, upon approval by the Commissioner. A foreign mutual insurer that is a party to the merger may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile. The provisions of subsection (b) of this Code section shall apply to a merger authorized under this subsection. (Code 1981, § 33-13A-4, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-5. Incorporation of reorganized insurer.

A mutual insurance holding company resulting from the reorganization of a domestic mutual insurer and the reorganized stock insurer shall be incorporated and governed pursuant to Chapter 14 of this title and subject to Chapter 13 of this title. This requirement shall supersede any conflicting provisions of Chapter 2 of Title 14. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the Commissioner in the same manner as those of an insurer. An intermediate stock holding company shall be incorporated and governed pursuant to Chapter 2 of Title 14. (Code 1981, § 33-13A-5, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-6. Required compliance; treatment of assets.

A mutual insurance holding company is deemed to be an insurer subject to this title and shall automatically be a party to any proceeding under this title involving an insurer that, as a result of a reorganization pursuant to Code Section 33-13A-3 or a merger pursuant to Code Section 33-13A-4, is a subsidiary of the mutual insurance holding company or one or more intermediate stock holding companies. In any proceeding involving the reorganized stock insurer, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized stock insurer for purposes of satisfying the claims of the reorganized stock insurer's policyholders. A mutual insurance holding company shall not be dissolved or liquidated without the prior approval of the Commissioner. (Code 1981, § 33-13A-6, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-7. Application of other statutory provisions.

(a) Code Section 33-14-76 is not applicable to a reorganization or merger pursuant to this chapter.

(b) The demutualization of a mutual insurance holding company is subject to the requirements of Code Section 33-14-76. (Code 1981, § 33-13A-7, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-8. Effect of membership interest.

A membership interest in a mutual insurance holding company shall not constitute a security as such term is defined in Code Section 11-8-102. (Code 1981, § 33-13A-8, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-9. Offerings of voting stock; duties of Commissioner.

(a) The offerings of voting stock by a reorganized stock insurer or intermediate stock holding company to any person other than the mutual insurance holding company or a wholly owned subsidiary thereof, which offering is to occur in connection with the reorganization or merger or is the first to occur after the effective date of the reorganization or merger, shall be made only in accordance with such provisions as the reorganization plan or merger plan may contain governing such an initial offering or with the prior approval of the Commissioner after submission of an application by the proposed issuer. The reorganization plan or merger plan shall describe the terms on which members, officers, and directors of the mutual insurance holding company, as well as any other persons, may participate in such offering. The Commissioner may approve any such application unless the Commissioner finds that the offering would be prejudicial to the members of the mutual holding company.

(b) The Commissioner may retain any attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing an application submitted pursuant to this Code section, the cost of which shall be borne by the proposed issuer submitting such application. (Code 1981, § 33-13A-9, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-10. Policyholder meetings.

(a) Within 45 days after the date of the Commissioner's approval of a reorganization plan or merger plan pursuant to this chapter, unless extended by the Commissioner for good cause, the mutual insurer shall hold a meeting of its policyholders to vote upon such plan. The mutual insurer shall give notice at least 30 days before the time fixed for the meeting, by first-class mail to the last known address of each policyholder, that the reorganization plan or merger plan will be voted upon at a regular or special meeting of the policyholders. The notice shall include a brief description of the reorganization plan or merger plan and a statement that the Commissioner has approved such plan. The notice shall also include information regarding where the policyholder can obtain copies of the full reorganization plan or merger at no cost to the policyholder. The notice to each policyholder shall also include a written proxy permitting the policyholder to vote for or against the reorganization plan or merger plan. A reorganization plan or merger plan shall be approved only if not less than two-thirds of the policyholders voting in person or by proxy at the meeting vote in favor of such plan. Each policyholder shall be entitled to only one vote regardless of the number of policies owned by the policyholder.

(b) If a mutual insurer complies substantially and in good faith with the notice requirements of this Code section, the mutual insurer's failure to give any policyholder any required notice does not impair the validity of any action taken under this Code section.

(c) For purposes of voting, policyholder means a person who is eligible to vote under the mutual insurer's articles of incorporation or bylaws and who is also a policyholder of the mutual insurer as of the date on which the reorganization plan or merger plan is initially approved by the board of directors of the mutual insurer. (Code 1981, § 33-13A-10, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-11. Treatment of stock.

The majority of the voting stock of the reorganized stock insurer, which is required by this Code section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subject to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate stock holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation of, in or on the majority of the voting stock of the reorganized stock insurer that is required by this Code section to be at all times owned by a mutual insurance holding company, is in violation of the provisions of this Code section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation as to the shares necessary to constitute a majority of such voting stock. The majority of the voting stock of the reorganized stock insurer that is required by this Code section to be at all times owned by a mutual insurance holding company shall not be subject to execution and levy. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized stock insurers or two or more intermediate stock holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this Code section to which the shares of the merging or consolidating reorganized stock insurers or intermediate stock holding companies were subject as provided in this Code section prior to the merger or consolidation. (Code 1981, § 33-13A-11, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-12. Legislative intent regarding impact on taxation.

It is the intent of the General Assembly that the formation of a mutual insurance holding company shall not increase the Georgia tax

burden of the mutual insurance holding company system and that a reorganized stock insurer shall continue to be subject to Georgia insurance premium taxation in lieu of all other taxes except as provided in Chapter 8 of this title. (Code 1981, § 33-13A-12, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

33-13A-13. Regulatory authority.

The Commissioner shall have the authority to promulgate rules and regulations to implement and enforce the provisions of this chapter. (Code 1981, § 33-13A-13, enacted by Ga. L. 2015, p. 846, § 3/HB 185.)

CHAPTER 20A

MANAGED HEALTH CARE PLANS

Article 1

Patient Protection

ARTICLE 1

PATIENT PROTECTION

33-20A-9.1. Legislative intent; consumer choice option; provisions; increased expenses; covered benefits; forms.

(a) It is the intent of the General Assembly to allow citizens to have the right to choose their own health care providers and hospitals with as few mandates from government and business as possible. It is also the intent to allow these choices with minimal additional cost to any business or consumer in this state.

(b) As used in this Code section, the term "consumer choice option" means a plan for health care delivery which grants enrollees a right to receive covered services outside of any plan provider panel and under the terms and conditions of the plan.

(c) Except for managed care plans offering a consumer choice option under subparagraph (d)(2)(C) of this Code section, every managed care plan offered by a managed care entity shall offer a separate consumer choice option to enrollees at least annually with the following provisions:

(1) Every enrollee of a managed care plan shall have the right to nominate one or more out of network health care providers or

hospitals for use by that enrollee and that enrollee's eligible dependents, if:

(A) Such health care provider or hospital is located within and licensed by the state;

(B) Such health care provider or hospital agrees to accept reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals. The reimbursement rates for the plan may be proportionally reduced from those paid to participating providers if the cost-sharing provisions in paragraph (3) of subsection (d) of this Code section are utilized in the consumer choice option;

(C) Such health care provider or hospital agrees to adhere to the managed care plan's quality assurance requirements and to provide the plan with necessary medical information related to such care; and

(D) Such health care provider or hospital meets all other reasonable criteria as required by the managed care plan of in network providers and hospitals; and

(2) Each nominated health care provider or hospital which meets the requirements of subparagraphs (A), (B), (C), and (D) of paragraph (1) of this subsection shall be reimbursed by the plan, subject to the agreement in subparagraph (B) of paragraph (1) of this subsection, as though it belonged to the managed care plan's provider network. Such reimbursement shall be full and final payment for the health care services provided to the enrollee and no health care provider or hospital shall bill the enrollee for any portion of a payment exclusive of the requirements of subparagraph (B) of paragraph (1) of this subsection.

(d)(1) An enrollee who selects the consumer choice option shall be responsible for any increases in premiums and cost sharing associated with the option; provided, however, that any differential in cost sharing as provided in paragraph (3) of this subsection shall only apply when the enrollee goes out of network.

(2) Any increases in premiums for the consumer choice option shall be limited as follows:

(A) For health benefit plans offered by health maintenance organizations under Chapter 21 of this title, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of

this option or a 17.5 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 15 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(B) For all other managed care plans under this chapter, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of this option or a 10 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 7.5 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(C) Notwithstanding subparagraph (B) of this paragraph, for all other managed care plans under this chapter, a health benefit plan may offer at no additional premiums or cost sharing a preferred provider organization network plan under Article 2 of Chapter 30 of this title, which plan contains standards for participating providers and hospitals which:

(i) Meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) of subsection (c) of this Code section; and

(ii) Includes only health care providers and hospitals which agree to accept the reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals and under any cost-sharing conditions required of other similarly situated preferred providers, which reimbursement shall be accepted as full and final payment for the covered health care services provided to the enrollee and no preferred provider shall bill the enrollee for any portion of a payment exclusive of the requirements of this subparagraph.

Managed care plans offering the preferred provider organization network plan under this subparagraph shall not place capacity limits on the number or classes of providers authorized to be

preferred providers except where the services regularly performed by a particular class of providers are not covered services within the scope of the health benefit plan or plans offered by the managed care plan pursuant to Article 2 of Chapter 30 of this title. This subparagraph shall not supersede any other requirement of this title regarding the coverage of a certain class or classes of providers.

(3) Except as provided in subparagraph (C) of paragraph (2) of this subsection for a consumer choice option without cost sharing, any increases in cost sharing for the consumer choice option, as compared to in network cost sharing, shall be limited as follows:

(A) If deductibles are used in network, any deductibles in the consumer choice option shall not exceed a 20 percent difference between in and out of network; provided, however, that deductibles cannot be accumulated separately between in network and out of network;

(B) If copayments are used in network, any copayments in the consumer choice option shall not exceed a 20 percent difference between in and out of network;

(C) In all cases, any coinsurance in the consumer choice option shall not exceed 10 percentage points difference between in and out of network; and

(D) In all cases, the maximum differential for out-of-pocket expenditures of the consumer choice option shall not exceed 20 percent as compared to in network; provided, however, that out-of-pocket expenditures cannot be accumulated separately between in network and out of network. Further, all cost sharing that is counted toward the out-of-pocket limit for the consumer choice option shall be the same as that counted toward the in network plan.

(4) After 12 months of full implementation, the pricing of the consumer choice option may be reevaluated to consider actual costs incurred and the experience of the standard plan without the option as compared to the consumer choice option. Based on an independent actuarial evaluation of such actual costs incurred and experience, managed care entities may apply for a waiver of the cost provisions of paragraphs (2) and (3) of this subsection to the Insurance Commissioner's office.

(e) The consumer choice option shall have substantially the same covered benefits as the managed care plan without the option.

(f) For an enrollee who chooses the consumer choice option, the managed care entity shall provide such enrollee with a form to be

completed by the enrollee nominated health care provider or hospital. This form shall indicate such health care provider's or hospital's agreement to accept reimbursement as provided in subparagraph (c)(1)(B) of this Code section and such health care provider's or hospital's agreement to adhere to the quality assurance requirements and other reasonable criteria of the plan as provided in subparagraphs (c)(1)(C) and (c)(1)(D) of this Code section. The form required by this subsection shall be one page, shall be signed and dated by the nominated health care provider or hospital, and shall be mailed to the managed care entity at the address indicated on the form. In a timely manner and upon receipt of such form from a nominated health care provider or hospital, the plan shall indicate acceptance of the health care provider or hospital and provide any necessary information to the health care provider or hospital including but not limited to a complete copy of the reimbursement terms, quality assurance requirements, and any other reasonable criteria required by the managed care plan of in network health care providers and hospitals. The plan may refuse to approve for reimbursement an enrollee nominated health care provider or hospital only upon a showing by clear and convincing evidence that the health care provider or hospital does not meet the requirements of paragraph (1) of subsection (c) of this Code section. (Code 1981, § 33-20A-9.1, enacted by Ga. L. 1999, p. 342, § 3; Ga. L. 2008, p. 1088, § 1/HB 1328; Ga. L. 2015, p. 1088, § 23/SB 148.)

The 2015 amendment, effective July 1, 2015, deleted "with copies to the consumers' insurance advocate on or after July 1, 2001" following "office" at the end of paragraph (d)(4).